this is further evidence that infection can occur as a result of licking.

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Factor VIII-von Willebrand factor in haemolytic uraemic syndrome

SIR,—We think that the terminology used by Drs J Kavi and R Wise with regard to factor VIII may cause confusion.[1] In their editorial they should not be referring to factor VIII but to von Willebrand's antigen (vWF:Ag), which has been shown to be raised in patients with haemolytic uraemic syndrome.

This confusion could have been avoided by using the internationally agreed standard nomenclature for factor VIII and von Willebrand factor.[2] In this nomenclature factor VIII refers to anti-haemophilic globulin and not to von Willebrand factor antigen, which is synthesised in endothelial cells. Von Willebrand factor is a large multimeric protein concerned in primary haemostasis and platelet aggregation which also acts as a carrier protein for factor VIII. We hope that this may clarify any confusion that may have arisen.

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AUTHOR'S REPLY,—Although we were aware of the internationally agreed standard nomenclature for factor VIII and von Willebrand factor, we used the term endothelial cell factor VIII in preference to von Willebrand factor in the interest of the general readership of the *BMJ*.

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Case finding in the elderly: Do general practitioners really know enough?

SIR,—Having read Ann Cartwright's and Christopher Smith's doubts about the knowledge of my primary health team being representative,[1] I would draw their attention to several points.

Firstly, their study defined the elderly as aged 65 or more.[2] This difference in age groups is critical when reviewing the published reports. This age group forms 15% of a practice population whereas that over 75 forms less than 6%.[3] If we repeated the exercise described[4] for our patients aged 65 or more I would expect our knowledge to be much less impressive as the consultation rates are lower for the 65-74 age group, especially for home visiting.[5]

Secondly, the knowledge presented was that of our primary health care team, not just that of the doctors. In fact, the receptionists had data on social aspects for about half the patients and data on certain functional aspects for three quarters of the patients. This must emphasise the little heeded role of receptionists in case finding of the elderly.

Thirdly, the sampling in the two studies is different, ours being a random one in two sample of the whole population aged 75 or more.

Fourthly, we were unaware of the involvement of health agencies in a quarter of the patients. This is owing to the method of collecting the data, which was without reference to the medical record. We did not assess prescribing.

The primary health care team in this practice is representative in its depth of knowledge and shows that good teamwork really does work well. Comparisons with other studies are hazardous because of the different criteria used.

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Screening for oral cancer

SIR,—Messrs J Bowden and C Scully highlight the need for regular oral examinations to detect early carcinoma.[1]

At present there is no organised screening to detect oral precancer either in the United Kingdom or in the Western world despite the fact that screening programmes for cancer elsewhere in the body have shown appreciable reductions in mortality and dentists themselves have shown a poor degree of diagnostic ability in their practices for early signs of disease.[2] Marks and Spencer Health Services with the Eastman Dental Hospital, London, is, however, pioneering a screening programme for the early detection of oral cancer and precancer. Initially, a pilot study with 1000 staff of Marks and Spencer will be carried out, and once the evaluation has been completed it is hoped to extend the screening programme to all staff.

It is hoped that the pilot study will help to promote a fundamental change of attitude and pave the way for nationwide comprehensive screening for oral precancer.

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Mental illness in doctors

SIR,—Though the editorial by Drs Lyn Pilowski and Geraldine O'Sullivan[1] is welcome, I would like to draw their attention to several points.

The consensus of informed opinion in the United States is that (*a*) the suicide rate for male doctors there is the same as that for age matched controls,[2] (*b*) female doctors have a suicide rate that is three to four times that of women who are not doctors but similar to that in male doctors,[3] and (*c*) psychiatrists seem to be overrepresented in the percentage of deaths due to suicide in doctors.[4] These facts emerged from three critical reviews of reports on suicide in doctors (E M Steindler, American Medical Association Student Association annual meeting, Houston, 1981)[5-7] and from the studies of Rich and Pitts and Pitts *et al*, who reviewed 18 730 consecutive deaths in doctors over five years.[2-4]

Evidence suggests, however, that the suicide rate among American doctors was appreciably higher 20 years ago and in line with the rate in Britain. The decline in the suicide rate has been suggested to result from the setting up of comprehensive sick doctor programmes throughout the United States.

The incidence of suicide among doctors in Britain is now more than three times higher than that for the general population (standardised mortality ratio 335%) and nearly twice that for males in social class I. The rate for female doctors is some six times that for women who are not doctors.[8]

Though it is to be hoped that the work of the National Counselling Service for Sick Doctors will diminish the suicide rate in Britain, its existence should not deter us from other efforts. Long before we get around to career reforms we ought to start caring for our colleagues, supporting each other, and ensuring that those of us who need treatment get it.

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Doctors becoming managers

SIR,—As one of the real McCoys—that is, doctor turned manager—I greatly enjoyed the conversation among Dr Richard Smith, Sir Anthony Grabham, and my colleague Professor Cyril Chantler.[1] But I take issue with Professor Chantler on one hoary old issue—the existence of the elusive entity "professional accountability." To implement a system of management accountability the medical and nursing professions have somehow been persuaded that they can keep their power base intact and their professional end up by this curious notion of dual accountability, of being managerially accountable to one person and professionally accountable to another.

Only in the health service do we entertain this notion that professionals can step back and have a double standard of accountability. Of course doctors, nurses, and managers are accountable to their patients, their colleagues in clinical units, and the General Medical Council and other professional bodies that govern the rules of their practice. Of course, juniors need to turn for supervision and training to their senior colleagues. But let us be in no doubt where accountability lies for the delivery of the work: that should be to the authority or agency for whom the work is contracted.

I faced this dilemma when I was the only doctor working as a junior researcher in a university department of sociology. I needed to turn regularly to senior psychiatric colleagues in other institutions for professional advice and support. But I always knew that the professor of sociology was my boss, that I was accountable to him for delivering proper psychiatric research advice. In the com-